Orthopedic Clinic of Central Virginia, P.C.

MEDICAL HISTORY FORM

Patient Name: *Gender:* *Chart No.*

Date of Birth: *Age:*

Information obtained from this Medical History Form will assist in evaluation and treatment of your condition. Information may be incorporated into the medical record / office notes as appropriate. This form is a worksheet which will not be retained in the permanent medical record.

Height: ______________________________ Weight:____________________________ ☐ Right-handed ☐ Left-handed

Indicate if you were referred here and/or how you chose to be seen here (check all that apply):

Referred by: ☐ Another doctor ☐ Urgent care ☐ Emergency department ☐ Employer ☐ Other: ________________________________

☐ Referred to orthopedics (no specific provider) ☐ Chose Dr. Biddulph from a list ☐ Referred specifcally to Dr. Biddulph

CHIEF COMPLAINT: What problem are you seeing the doctor for today?

____

HISTORY OF PRESENT ILLNESS:

Please give a brief description of the problem for which you are being seen today: ____

____

____

When did you first notice this problem? ____

Can you recall what you were doing when the pain/problem started? ____

____

____

____

How severe is the pain/problem? ☐ Mild ☐ Moderate ☐ Moderately severe ☐ Severe ☐ Other: ________________________

How often do you have symptoms? ☐ Rarely ☐ Every few days ☐ Once or twice per day ☐ Many times per day ☐ Constantly

☐ Other: ____ How long do the symptoms last? ________________________

____

When was the last time you recall having symptoms? ____

____

Do the symptom(s) radiate (extend) to other areas? ☐ No ☐ Yes____

In the past, have you experienced any injury or symptoms regarding this body part? ☐ Yes ☐ No

If yes, describe: ____

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Orthopedic Clinic of Central Virginia, P.C.

MEDICAL HISTORY FORM (Page 2)

Patient Name: *Chart No.*

Date of Birth: *Age:*

Symptoms include (check all that apply): ☐ N/A ☐ Pain ☐ Numbness ☐ Tingling ☐ Catching ☐ Popping ☐ Grinding
☐ Locking ☐ Instability ☐ Swelling ☐ Stiffness ☐ Weakness ☐ Loss of control of bowels/bladder

☐ Other: ____

List any activities that make the problem worse: ____

List any activities that make the problem better: ____

List any previous evaluation or diagnostic testing that you have had for this condition (check all that apply):

☐ None ☐ Urgent care ☐ ER ☐ Primary care ☐ Orthopedics ☐ Other: ____________________

Facility/Physician Visited: ____

☐ X-ray ☐ MRI ☐ Ultrasound ☐ Other diagnostic tests: ______________________________

What treatment has been tried for this condition prior to today's visit? (check all that apply): ☐ None

☐ Physical Therapy Was it helpful? ☐ Yes ☐ No ☐ Other: ____________________

☐ Injection Have injection(s) been helpful? ☐ Yes ☐ No ☐ Other: ____________________

☐ Anti-inflammatory medications (NSAIDS - specify): ____________________ Are NSAIDS helpful? ☐ Yes ☐ No

☐ Pain medications (opioids/controlled substances - specify): ______________________________

Are opioid/controlled substance pain medications helpful? ☐ Yes ☐ No ☐ Other: ____________________

☐ Other treatment: ____

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Orthopedic Clinic of Central Virginia, P.C.

MEDICAL HISTORY FORM (Page 3)

Patient Name: *Chart Number:*

Date of Birth: *Age:*

What is your job title/occupation? ______

Is your work physically demanding? ______

Does your condition limit your ability to continue working? ______

______

Please list any sports or other physical activities in which you are regularly involved and indicate if your condition has limited your ability to continue these activities: ______

______

Provide any additional information that you would like the doctor to know about your condition: ______

______

______

Please list any specific objectives you may have related to your condition (check all that apply):

☐ Eliminate pain ☐ Improve function ☐ Make sure nothing is seriously wrong ☐ Other: ______

Do you want to request any specific treatment or tests? (check all that apply): ☐ Whatever is recommended

☐ MRI ☐ Xrays ☐ Surgery ☐ No surgery ☐ Cast ☐ No cast ☐ Cortisone injection ☐ Excuse for work / school

☐ Physical Therapy ☐ Pain medications ☐ Other: ______

Is today's visit related to an injury? ☐ No - please proceed to the next page

☐ Yes - please complete the following:

Date of Injury: ______

The injury is due to: ☐ Work injury ☐ Car accident ☐ Sports injury ☐ Fall ☐ Other: ______

The injury occurred at: ☐ Work ☐ Home ☐ School ☐ Other: ______

Work status:

☐ Not working: Last day worked: ______

☐ Working with the following restrictions: ______

☐ Working without any restrictions

Is legal action/litigation pending due to this injury? ☐ No ☐ Yes: ______

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Orthopedic Clinic of Central Virginia, P.C.

MEDICAL HISTORY FORM (Page 4)

Patient Name: *Chart Number:*

Date of Birth: *Age:*

PAST MEDICAL HISTORY: Have you ever had any of the following? *Check all that apply*: ☐ None

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ COPD
- ☐ Epilepsy/seizures
- ☐ Kidney disease
- ☐ Chronic back pain
- ☐ Chronic neck pain
- ☐ Lymphdema
- ☐ Migraine headaches
- ☐ Anxiety
- ☐ Depression: ____________________
- ☐ Diabetes
- ☐ Stroke/TIA: ____________________
- ☐ Peripheral vascular disease/poor circulation
- ☐ Hypertension (high blood pressure)
- ☐ Bleeding problems: ____________________
- ☐ Blood transfusions
- ☐ Blood clots/DVT/pulmonary embolism (PE)
- ☐ Thyroid problems:
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism
- ☐ Ulcers: ____________________
- ☐ Reflux: ____________________
- ☐ High cholesterol
- ☐ Hyperlipidemia
- ☐ Liver disease/hepatitis/cirrhosis
- ☐ Heart problems/surgery (check all that apply)
  - ☐ Coronary artery disease
  - ☐ Myocardial infarction ("heart attack")
  - ☐ Atrial fibrillation
  - ☐ Heart failure
  - ☐ Pacemaker/defibrillator
  - ☐ Cardiac catherization/angioplasty/stents
  - ☐ Other: ____________________
- ☐ Sleep Apnea
  - ☐ CPAP used: ____________________
- ☐ Cancer (list type and treatment
  ____
  ____
  ____
- ☐ Other condition(s) not listed above:
  ____
  ____

PAST SURGICAL / HOSPITALIZATION HISTORY: Include approximate date, location and surgeon, if known ☐ None

____
____
____
____
____

PRIOR INJURIES / ACCIDENTS (not previously listed): ☐ None

____
____
____

REPRODUCTIVE HISTORY (FEMALES):

Are you pregnant? ☐ No ☐ Yes* ☐ Possibly* **please notify staff prior to any imaging studies or treatment*

Last menstrual period: ____________________ ☐ Post-menopausal ☐ Hysterectomy ☐ Implant: ____________________

Adolescent females: Age at menarche (first menstrual period): ____________________ ☐ Premenarchal (no periods yet)

MEDICATIONS: List all medications (including over-the-counter medications & supplements) that you are currently taking ☐ None

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

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Orthopedic Clinic of Central Virginia, P.C.

MEDICAL HISTORY FORM (Page 5)

Patient Name: *Chart Number:*

Date of Birth: *Age:*

ALLERGIES / REACTIONS:

Medication allergies (include the reaction you have to the medication): ☐ None known

List only medications that cause **ALLERGIC** reactions such as swelling, rash, hives, difficulty breathing/anaphylaxis, etc.

______________________ ______________________

______________________ ______________________

______________________ ______________________

Other adverse reactions / side effects to medications (include the reaction you had to the medication)

List only medications that cause problems **OTHER THAN** swelling, rash, hives, difficulty breathing/anaphylaxis, etc. ☐ None

______________________ ______________________

______________________ ______________________

Have you had an allergic reaction to latex? ☐ No ☐ Yes (list reaction): ______________________

Food allergies (list food and reaction): ☐ None known ______________________

____

FAMILY HISTORY: List any conditions that are present in anyone closely related to you: ☐ None / unknown

☐ Severe reaction to anesthesthesia (e.g. malignant hyperthermia): ______________________

☐ Diabetes ☐ Cancer ______________________

☐ Bleeding disorders ☐ Other ______________________

SOCIAL HISTORY:

***Marital Status*:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: ______________________

Living Situation (check all that apply):

☐ Live alone ☐ Live with family ☐ Other: ______________________

Reside in: ☐ Fredericksburg City ☐ Spotsylvania ☐ Stafford ☐ Other: ______________________

Employer / location of work: ______________________

☐ Place of birth (if outside USA): ______________________

☐ Native language (if other than English): ______________________

Tobacco History (check all that apply):

☐ Never used tobacco products ☐ Stopped using tobacco products: ______________________

☐ Currently smoke cigarettes __________ packs per day ☐ Currently smoke cigars/pipe __________ times per day/week

☐ Currently use smokeless tobacco ☐ Currently use E-cigarettes __________ times per day/week

Alcohol History (check all that apply):

☐ Previous history of alcoholism/dependency ☐ I don't drink alcohol ☐ I drink rarely

☐ I consume approximately ____________ alcoholic beverages per ☐ day ☐ week ☐ month

Recreational drug use ☐ No ☐ Yes: ______________________

Orthopedic Clinic of Central Virginia, P.C.

MEDICAL HISTORY FORM (Page 6)

Patient Name: *Chart Number:*

Date of Birth: *Age:*

MEDICAL PROVIDERS:

Are you under the care of a primary care provider? ☐ No ☐ Yes (name and location) ______________________

Are you under the care of a pain management physician? ☐ No ☐ Yes: ______________________

Are you prescribed opioid/controlled pain medications regularly? ☐ No ☐ Yes*: ______________________

*If yes, have you signed an opioid agreement? ☐ No ☐ Yes

List any other doctors/medical providers from which you receive care regulary: ☐ None

☐ Cardiologist: ______________________ ☐ Neurolgist: ______________________

☐ Urgent care: ______________________ ☐ Other: ______________________

REVIEW OF SYSTEMS: Are you currently or regularly experiencing any of the following symptoms? ☐ **NONE**

Completion of this section will help identify health conditions unrelated to your orthopedic condition. These conditions will not be addressed by the orthopedic physician. It is your responsibility to report these conditions to appropriate medical providers (e.g., primary care doctor, urgent care facility, or emergency department).

Musculoskeletal (if not noted above)

Symptom		
Joint pain	No	Yes
Back pain	No	Yes
Neck pain	No	Yes
Joint swelling	No	Yes

Ears/ Nose/ Mouth/ Throat

Symptom		
Hearing loss	No	Yes
Chronic sinus problems	No	Yes
Swollen glands in neck	No	Yes
Loose or painful teeth	No	Yes

Genitournary

Symptom		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Incontinence	No	Yes

Constitutional

Symptom		
Recent weight loss	No	Yes
Fever/chills	No	Yes
Night sweats	No	Yes

Integument (Skin)

Symptom		
Rash	No	Yes
Varicose veins	No	Yes
Skin disease	No	Yes

Cardiovascular

Symptom		
Chest pain	No	Yes
Abnormal heart rhythm	No	Yes
Poor circulation	No	Yes

Neurological

Symptom		
Numbness or tingling	No	Yes
Tremors	No	Yes
Headaches	No	Yes
Paralysis	No	Yes

Endocrine

Symptom		
Excessive thirst	No	Yes
Heat or cold intolerance	No	Yes

Respiratory

Symptom		
Frequent cough	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Allergy/Immunologic

Symptom		
Environmental allergies	No	Yes
Food allergies	No	Yes

Hematologic/Lymphatic

Symptom		
Bleeding	No	Yes
Bruising	No	Yes
Swollen lymph nodes	No	Yes

Psychiatric

Symptom		
Memory loss	No	Yes
Anxiety	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Claustrophobia	No	Yes

Gastrointestinal

Symptom		
Nausea/vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Abdominal pain	No	Yes
Heartburn	No	Yes
Intolerance to NSAIDs	No	Yes

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